

SYMPHYSIOTOMY WITH OSTEOPLASTIC RESTORATION OF THE SYMPHYSIS.

In the *Centralblatt für Gynäkologie*, 1895, No. 43, GEUER describes the case of a primigravida who was delivered by symphysiotomy and the use of forceps. As the vagina was small and illy-developed, the tissues were extensively lacerated, the anterior wall of the vagina being opened so that a communication existed between the symphysiotomy wound and the tear in the vagina. The lacerations were closed by sutures, and the symphysis wired together with silver wire. The wound became infected, and the patient made a tedious convalescence, being ill two months. The symphysis failed to unite, and after recovery from her labor the two halves of the pubic joint remained 2 cm. asunder. To remedy this defect, the old incision was reopened, and a flap of periosteum and bone was loosened from the ramus of the pubes, and turned upon its axis, and inserted between the cut ends of the pubic joint, which had been previously freshened. The skin was closed by dissecting up a flap and sliding it over the site of the original scar, which had been excised. The patient was convalescent in two weeks after the operation. Bony union was complete, and the patient could move about as well as before her labor. The pelvis was considerably enlarged, from one-half to one and one-half cm. in each measurement. Both the external and internal conjugates were increased one and one-half cms.

In discussing the performance of this operation at the time of labor, the writer is inclined to believe that the best results will be obtained when this procedure is deferred until after convalescence from labor. He would wait at least two weeks after the original symphysiotomy. He also states that, during the months of August and September last, five cases were operated upon by FRANK, in which the flap of bone and periosteum was placed within the symphysis at the time of delivery. The results of these five operations were all good.

A CASE OF SPONTANEOUS EVOLUTION DURING LABOR IN A PRIMIPARA.

The spontaneous termination of labor in transverse presentations is an occurrence of rarity even with multiparæ, and in patients having large pelves. The following case, occurring in a primipara, is certainly remarkable. GRASEMANN (*Centralblatt für Gynäkologie*, 1895, No. 43) reports the case of a primipara, a slender and not especially robust woman, whose pelvis was very slightly flattened, and in whom the fetus lay in transverse presentation, the back directed posteriorly, the right arm having been forced down and into the vagina. The right shoulder was firmly wedged into the pelvis, and the chest of the child was deep in the pelvis. The head and breech had been forced upward. Uterine contractions were exceedingly strong. The patient was placed at the edge of a table, and an endeavor made to push up the arm and shoulder and perform podalic version. This failed entirely, as uterine rupture threatened during the attempt. One of two courses seemed possible for the physician in attendance: to perform embryotomy or to await the spontaneous expulsion of the fetus. While preparing for embryotomy, the right shoulder was forced downward and

gradually expelled, followed by the birth of the left arm and shoulder, then the chest and breech, and, finally, the legs were spontaneously delivered. The head was readily delivered by the attending physician. The pelvic floor and perineum were uninjured. The child had but recently died, was at full term, and of average length. The patient made an uninterrupted recovery.

GYNECOLOGY.

UNDER THE CHARGE OF

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OPERATION FOR CYSTOCELE.

HADRA (*Centralblatt für Gynäkologie*, 1895, No. 26) calls attention to the fact that cystocele is not cured either by ventro-fixation or by Alexander's operation, unless the natural curve of the anterior wall is also restored by shortening it antero-posteriorly. To accomplish this he dissects off a broad crescentic flap from the anterior lip of the cervix, which extends on both sides down the vaginal wall. The anterior vaginal wall is then drawn upward until the cystocele disappears, and the redundant portion of the flap is excised. While the left forefinger of the operator lifts up and protects the bladder, the cervix is drawn downward and backward by an assistant, and the vaginal flap is united to the cervix by silk-worm-gut sutures.

The ordinary operations for cystocele aim at simply removing redundant tissue without restoring the relations of the portio and anterior fornix, as is done by the procedure before described.

The same operation is applicable to retroflexion with rectocele and cystocele, being supplemented by colpo-perineorrhaphy, and may be substituted for vagino-fixation in a considerable proportion of such cases. It has the advantage of leaving the uterus in a more nearly normal position than after the latter operation.

THE PROPHYLACTIC TREATMENT OF VESICO-VAGINAL FISTULA.

SCHULTZE (*Centralblatt für Gynäkologie*, 1895, No. 27) calls attention to the fact that cervico-vesico-vaginal fistulæ tend to heal spontaneously, and that they are more frequent after labor than is generally supposed. On the contrary, minute vesico-vaginal fistulæ often require operative treatment.

Prolonged pressure of the head in delayed first stage after premature escape of the liquor amnii, especially in cases of contracted pelvis, is more apt to be the cause of cervico-vesical fistulæ than is instrumental delivery, although the laity are prone to attribute it to the latter. The unwise use of ergot is another prominent etiological factor.

After all difficult labors, in which the bladder has been subjected to prolonged pressure, the urine should be drawn regularly every eight hours for a few days. By adopting this simple procedure a considerable proportion of the cases of vesico-vaginal fistula can be prevented.